Dr. Julie Oh, O.D.
1 W. Duarte Rd., Suite B.
Arcadia, CA 91007

PREMIER VISION
OPTOMETRY

Tel: 626-446-6300
Fax: 626-446-6301
www.pvoptometry.com

*IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions./ 請盡您所能回答所有問題*

| PATIENT INFORMATION /病人資料 | | | |
|---|---|---|---|
| First Name/名字: | Patient's Last Name /姓: | Sex/性別: ❑ M/男 ❑ F/女<br>Age/年齡: | Birth Date /出生日期:<br>/ / |
| Occupation/職業: | Employer/雇主: | Social Security No./ 社會安全號碼:: | |
| Street Address/地址: | City/城市: | State/ 州: | ZIP Code/郵政編碼: |
| Home Phone No./電話號碼: | Work Phone No./工作電話: | Cell Phone No./ 手機: | |
| E-mail/電子郵件: | How did you hear about us/介紹人: | | |
| Emergency Contact Name & Phone No./緊急聯絡人姓名及電話: | | | |

| INSURANCE INFORMATION/保險資料 | | | | | |
|---|---|---|---|---|---|
| Insurance Card/ID No./ 保險號碼: | | | | | |
| Type of Insurance/保險類別: | ❑ VSP | ❑ EyeMed | ❑ MES | ❑ Medicare | ❑ BlueCross PPO |
| Name of Insured/被保險人姓名: | SSN of Insured/被保險人社會安全號碼: | Birth Date of Insured/被保險人出生日期:<br>/ / | | | |
| Relationship to insured/<br>與保險人的關係: | ❑ Self/自己 | ❑ Spouse/配偶 | ❑ Child/孩子 | ❑ Parent/家長 | ❑Other (specify)/ 其他(註名): |

***NOTE: INSURANCE CARD AND CO-PAYMENT MUST BE PRESENT AT TIME OF SERVICE.***

| MEDICAL INFORMATION/病人醫療資料 | | |
|---|---|---|
| Allergies/過敏: ____________<br>❑ None/無 | Ocular History/眼科歷史: ____________<br>❑ None/無 | ❑ Pregnant/懷孕<br>❑Wear glasses/戴眼鏡<br>❑Wear contact lenses/戴隱形眼鏡 |
| Medication/藥物: ____________<br>❑ None/無 | Injuries or Surgeries/手術: ____________<br>❑ None/無 | ❑Soft/軟式 ❑ Hard/硬式<br>❑ Comfortable/舒適 |

| Social History/個人生活的歷史 |
|---|
| ❑ Doesn't Drive/不開車 ❑ Drive/開車 Driving Difficulties/駕駛困難: |
| ❑ Doesn't use Tobacco/不抽煙 ❑ Use Tobacco/抽煙 Type/Amt/How long/類型，數量，多久: |
| ❑ Doesn't Drink Alcohol/不喝酒 ❑ Drink Alcohol/喝酒 Type/Amt/How long/類型，數量，多久: |
| ❑ Doesn't Use Illegal Drugs/不使用非法藥品 ❑ Use Illegal Drugs/使用非法藥品<br>Type/Amt/How long/類型，數量，多久: |

| **Premier Vision Optometry Policy / 退款規定** | |
|---|---|
| **No refunds allowed. Store credit only. /**出售的商品嚴格不予退款. 予店內消費金額而非現金 | |
| ____________________<br>Patient/Guardian Signature/病人或監護人簽名 | ____________<br>Date/日期 |

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## PERSONAL Review of Systems. Please check all that apply to you/請選擇所有你有的病症或問題

**EYES/ 眼睛**
- ❑ Vision Loss/视力喪失
- ❑ Blurry Vision/视力模糊
- ❑ Distorted Vision/视觉扭曲
- ❑ Double Vision/重视
- ❑ Dryness/乾眼
- ❑ Redness/紅眼
- ❑ Mucous Discharge/粘液排放
- ❑ Gritty Feeling/沙粒的感覺
- ❑ Itching/癢的感覺
- ❑ Burning/烧灼的感覺
- ❑ Excess Watering/過量出水
- ❑ Light Sensitivity/光敏感
- ❑ Eye Pain or Soreness/眼痛或酸痛
- ❑ Chronic Infection/慢性感染
- ❑ Flashes/閃爍
- ❑ Floating Spots/漂浮點
- ❑ Tired Eyes/眼睛疲倦
- ❑ Cataracts/白内障
- ❑ Diabetic Retinopathy/糖尿病性視網膜病變
- ❑ Glaucoma/青光眼
- ❑ Macular Degeneration/黄斑變性
- ❑ Retinal Detachment/視網膜脫離

**GASTROINTESTINAL/ 胃腸道**
- ❑ Colitis/結腸炎
- ❑ Crohn's Disease/節段性回腸炎病
- ❑ Ulcers/潰瘍
- ❑ Constipation/便秘
- ❑ Diarrhea/腹瀉

**CONSTITUTIONAL/全身的**
- ❑ Fever/發燒
- ❑ Weight Loss or Gain/體重變化
- ❑ Fatigue/疲勞
- ❑ Trauma/創傷

**INTEGUMENTARY (SKIN)/ 外皮的**
- ❑ Eczema/濕疹
- ❑ Rosacea/酒渣鼻
- ❑ Psoriasis/ 疥癬

**NEUROLOGIC/ 神經**
- ❑ Headaches/頭痛
- ❑ Migraines/偏頭痛
- ❑ Seizures/癲癇
- ❑ Mult.Sclerosis/ 多發性硬化症

**ENDOCRINE/ 内分泌**
- ❑ Non Insulin Diabetes /非胰島素糖尿病
- ❑ Insulin Diabetes/胰島素糖尿病
- ❑ Thyroid Dysfunction/甲狀腺功能減退
- ❑ Hormonal Dysfunction/荷爾蒙功能減退

**RESPIRATORY/ 呼吸**
- ❑ Asthma/ 氣喘
- ❑ Bronchitis/ 支氣管炎
- ❑ Emphysema /氣腫

**CARDIOVASCULAR /心血管**
- ❑ Heart Disease/心臟疾病
- ❑ Hypercholesterolemia/高膽固醇血症
- ❑ Hypertension/高血壓

**EARS/NOSE/THROAT / 耳/ 鼻/ 喉**
- ❑ Allergies/過敏
- ❑ Sinus Congestion/鼻竇充血
- ❑ Runny Nose/流鼻涕
- ❑ Post Nasal Drip/ 鼻滴水
- ❑ Chronic Cough/慢性咳嗽
- ❑ Dry Throat/Mouth/咽喉乾燥

**ALLERGIC/IMMUNE / 過敏/免疫**
- ❑ Drug Allergies/藥物過敏
- ❑ Seasonal Allergies/季節性過敏
- ❑ Lupus/狼瘡
- ❑ Arthritis/關節炎

**LYMPHATIC/HEMATOLOGIC/ 淋巴/血液**
- ❑ Anemia/貧血
- ❑ Bleeding Problems/出血問題
- ❑ Leukemia/白血病

**MUSCULOSKELETAL/ 肌肉骨骼**
- ❑ Fibromyalgia/纖維肌痛
- ❑ Muscular Dystrophy/肌肉萎縮症
- ❑ Osteoarthritis/骨性關節炎
- ❑ Ankylosing Spond./ 強直性脊柱炎

**GENITOURINARY/ 泌尿生殖系**
- ❑ Kidney problems/腎臟問題
- ❑ Bladder problems/膀胱問題
- ❑ STDs/性病
- ❑ Other/其他

## FAMILY Medical History: Note relation to yourself (example: "mother")/家庭成員醫療資料，请注明和自己的關係（例如：母親）

- ❑ Blindness/失明
- ❑ Cataracts/白内障
- ❑ Macular degeneration/黄斑變性
- ❑ Glaucoma/青光眼
- ❑ Retinal detachment/視網膜脫離
- ❑ Crossed Eyes/鬥雞眼
- ❑ Lupus/狼瘡
- ❑ Other/其他
- ❑ Cancer/癌症
- ❑ Lupus/狼瘡
- ❑ Heart Disease/心血管疾病
- ❑ High Blood Pressure/高血壓
- ❑ Kidney Disease/腎臟病
- ❑ Arthritis/關節炎
- ❑ Thyroid Disease/甲狀腺疾病
- ❑ None/無

## DISCLAIMER/聲明

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment of all services or materials provided to me. I also authorize Premier Vision Optometry to release any information required to process my claims.
上述信息是真實的。我知道，我將負責支付所有提供給我的服務或材料。我還授權 *Premier Vision Optometry* 釋放任何所需資料以便處理我的保險索賠。

Patient/Guardian Signature/病人或監護人簽名 ______________________ Date/日期 ______________________

**HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your demographic information that may identify you and that relates to your past, present or future physical and mental health or condition and related health care services.

**Uses and Disclosure of Protected Health Information**

Your PHI may be used and disclosed by your doctor, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice, and any other use required by law.

**Treatment**

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for the procedure.

**Health Care Operations**

We may use or disclose, as needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your PHI to optometry school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI without your authorization in these situations: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

**Acknowledgement of Financial Responsibility**

You, as a patient, are ultimately responsible for all fees. We do accept insurance assignment and will file your insurance claim for you; however, you are still responsible for all co-payments or balance as required by your specific insurance plan. You are required to bring you insurance card to each visit. If your insurance requires a referral, this must be obtained from your primary care physician prior to coming in to the office. All co-payment and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary co-payments, co-insurance, and deductibles. We accept cash or check. We will try to obtain pre-approval for treatments and procedures from you insurance company; however, if the insurance company refuses to pay for any reason, you are ultimately responsible for the fees for treatments and procedures.

***My signature below acknowledges that the HIPAA Notice of our Privacy Practices has been received, read and understood by me, and I will be ultimately responsible for all the fees for office visits, treatments and procedures.***

**Print Patient Name:** ____________________________________________

**Patient/Guardian Signature:**______________________________ **Date:**________________________